20a & 20b

These two selections are from articles written 17 years apart about states on opposite coasts of the country. The first article was written before the advent of large scale de-institutionalization ; the second was written after.

Despite these differences both articles describe the same phenomenon. What is it ?

The relations between community mental health programs and state mental hospitals are beset with problems that require solution. The author discusses the nature of these problems and some ways of dealing with them.

PROBLEMS IN RELATING COMMUNITY PROGRAMS TO STATE HOSPITALS

Hyman M. Forstenzer, M.S., F.A.P.H.A.

New York State's Community Mental Health Services Act, and most other state-wide efforts to develop mental health services at the community level, came into being largely as a result of frustrations caused by an almost complete reliance on state mental hospitals to cope with the problems of mental illness. After more than four years of experience in the administration of the New York State community program, I see more clearly than ever the pertinence of the following comment by Sir Geoffrey Vickers in an address on "What Sets the Goals of Public Health." "In 1946," Vickers said, "the British Parliament, with the passing of the National Assistance Act, thought it had destroyed the last vestiges of that 'New Poor Law' which the reformers of 1834 expected to abolish destitution. Yet every page of the new statute reflects attitudes which are not responses to the future but protests against the past. It is not only soldiers who start each war perfectly equipped to win the one before."[1]

Are our present efforts to develop community mental health programs more a protest against the state hospitals of the past than an attempt to meet the present and future needs of the mentally ill? I believe that our most important and most immediate need is to develop a working partnership between community services and facilities and the state hospital systems. Unless this is accomplished, I fear that we run the risk of solidifying two separate and distinct programs, both operating at less than optimal levels, each handicapping the other, and each presumably concerned with different portions of the range of mental illnesses and possibly with different segments of the total population. An adequate system for the control of mental illness in populations cannot be developed with the present dichotomy of community and state hospital services.

Right now, one wonders how the "Closed Ranks"[7] of communities toward the seriously ill can be broken in the absence of leadership by example on the part of the community specialists in mental illness. Close observation of the practices of outpatient community services over a full decade forces the conclusion that as far as the seriously mentally ill are concerned the ranks of community service personnel are almost as closed as are those of the total community. This may be the result of differences in values or in role concept, of economics, or of training. Whatever the cause, it is important to note that community mental health specialists by and large play no role in the care and rehabilitation of the seriously ill in their communities. The original rationale for mental hygiene clinics, namely, to prevent psychosis by treating nonpsychotic psychiatric cases still seems to govern clinic practice although it has never been validated and most clinicians have quite properly stopped using it as a justification for support of clinics.

The relationship between community inpatient facilities and the state hospitals presents another set of problems. First, there is the still strong resistance of general hospital boards and staff to the development of psychiatric services within the general hospital. Second, there is the preoccupation of the large, municipally operated, general hospital psychiatric divisions with screening patients to determine whether treatment is necessary. Here the prevailing pattern of distribution of fiscal responsibility for the hospital care of the mentally ill plays a significant part. In most states, mental hospitals are entirely supported by state government with no charge back to local government. Local fiscal authorities exert pressures on local mental health specialists in publicly supported general hospitals to quickly arrange state hospital admission for those for whom treatment is considered necessary and to discharge the others back to the community. The determination is rarely made on the basis of what can be done for the patient through short-term treatment programs within the general hospital.

Some of the problems in relating community programs to state hospitals have been described. There are many others, but none of them are insoluble. Until they are solved, it is unlikely that we will develop an effective program for the control of mental disorders in large populations.

REFERENCES

1. Vickers, Sir Geoffrey. "What Sets the Goals of Public Health?" Address given at the School of Public Health, Harvard University, November 26, 1957.
2. Statistical Services, Division of Research and Medical Services, New York State Department of Mental Hygiene, Albany, N. Y.
3. Hunt, Robert C. Community Responsibility for Mental Health in Britain, the Netherlands, and New York State. Psychiatric Quart. 30,684-697 (Oct.), 1956.
4. Mental Health Bill, Bill 53; House of Commons. Ordered printed December 17, 1958. London, England: Her Majesty's Stationery Office.
5. Statistical Services, Division of Research and Medical Services, New York State Department of Mental Hygiene, Albany, N. Y.
6. Distribution of Patients by County of Origin. Informational Bull. No. 1. Department of Mental Hygiene, State of California, Statistical Research Bureau (Apr.), 1958.
7. Cumming, Elaine, and Cumming, John. Closed Ranks. Cambridge, Mass.: Harvard University Press, 1957.

Mr. Forstenzer is director, Community Mental Health Services, New York State Department of Mental Hygiene, Albany, N. Y.

This paper was presented before a Joint Symposium of the American Orthopsychiatric Association and the Mental Health Section of the American Public Health Association at the Annual Meeting of the American Orthopsychiatric Association in San Francisco, Calif., March 30, 1959.

FROM: Cameron, J. (1978). Ideology and Policy Termination: Restructuring California's Mental Health System. Public Policy 26: 533-70

20 b

Fragmentation of Control. The lack of aftercare services for former hospital patients can be traced, in large part, to the pattern of radical decentralization that accompanied implementation of the new law. Although the legislature attempted to shore up certain provisions of L-P-S* in order to induce the counties to increase their efforts in the provision of aftercare services, its efforts had little effect. Local programs, oriented toward the voluntary, easier-to-manage clients, had developed independently of the state hospitals, whose programs

were oriented toward the more seriously disordered. The counties' response to this new population was colored by a history of serving what was essentially another type of clientele. Organizational technologies had been constructed, roles elaborated, and routines established that were consistent with the new, and professionally exciting, approach of community mental health. Caring for the chronically mentally ill was not considered part of their professional domain.[15] In spite of the tremendous increase in State expenditures for local mental health programs—from $27.5 million in fiscal year 1969 to $185.5 million in fiscal year 1976—local programs were disinclined to target community mental health dollars specifically to the types of patients who were prone to be hospitalized.

It is to be expected that when one level of government controls the purse strings for another, some degree of accountability will be exercised. In the California mental health system, however, the State relinquished control of programs in its effort to disengage itself from the delivery of direct services. The new mental health law was designed to provide for a single system of care in which the counties assumed responsibility for the provision of services. The manner in which the system was decentralized, however, precluded the State from exercising programmatic control. The county programs, which had traditionally functioned autonomously, were free to develop their patterns of service delivery unfettered by State intervention.

* L-P-S is Cameron's abbreviation for the Lanterman-Petris-Short Act, passed in 1968. This legislation modified California's original community mental health services act (1957) in several ways. I will summarize the modifications in our discussion.